C. NON-INSTITUTIONAL

WAC 388-513-1305 Determining eligibility for non-institutional medical assistance in an alternate living facility (ALF).

This section describes how the department defines the monthly income standard and uses it to determine eligibility for non-institutional medical assistance for a client who lives in a department-contracted ALF. Refer to WAC 388-478-0045 for the personal needs allowance (PNA) amount that applies in this rule.

(1) Alternate living facilities include the following:

(a) An adult family home (AFH);

(b) An adult residential care facility (ARC);

(c) An adult residential rehabilitation center (ARRC);

(d) An adult residential treatment facility (ARTF);

(e) An assisted living facility (AL);

(f) A division of developmental disabilities (DDD) group home (GH); and

(g) An enhanced adult residential care facility (EARC).

(2) The monthly income standard for non-institutional medical assistance under the categorically needy (CN) program that cannot exceed the special income level (SIL) equals the following amounts. For a client who lives in:

(a) An ARC, an ARRC, an ARTF, an AL, a DDD GH, or an EARC, the department-contracted rate based on a thirty-one day month plus the PNA.

(b) An AFH, the department-contracted rate based on a thirty-one day month plus the PNA plus the cost of any add-on hours authorized by the department; or

(3) The monthly income standard for non-institutional medical assistance under the medically needy (MN) program equals the private facility rate based on a thirty-one-day month plus the PNA.

(4) The monthly income standard for non-institutional medical assistance under the general assistance (GA) program equals the GA grant standard described in WAC 388-478-0030.

(5) The department determines a client's non-excluded resources as described in chapter 388-470 WAC and WAC 388-505-0595.

(6) The department determines a client's non-excluded income as described in chapter 388-450 WAC, WAC 388-505-0595, WAC 388-506-0620 and WAC 388-511-1130.

(7) The department approves CN non-institutional medical assistance for a period of up to twelve months for a client who receives Supplemental Security Income (SSI) or who is SSI-related as described in WAC 388-503-0510 (1), if:

(a) The client's non-excluded resources described in subsection (5) do not exceed the standard described in WAC 388-513-1350 (1); and

(b) The client's non-excluded income described in subsection (6) does not exceed the CN standard described in subsection (2).

(8) The department approves MN non-institutional medical assistance for a period of months described in chapter 388-416 WAC for an SSI-related client, if:

(a) The client's non-excluded resources described in subsection (5) do not exceed the standard described in WAC 388-513-1350 (1); and

(b) The client satisfies any spenddown liability as described in chapter 388-519 WAC.

(9) The department approves GA non-institutional medical assistance for a period of months described in chapter 388-416 WAC for a client determined eligible for the program as described in WAC 388-400-0025.

(10) The client described in subsections (7) and (9) keeps the PNA amount and pays remaining income to the facility for board and room.

CLARIFYING INFORMATION

Facility rates are contracted individually and can vary from one facility to another. The department authorizes additional personal care service/add-on hours for a client assessed as requiring such services due to a handicapping condition. The department

establishes and pays an hourly rate to a contracted agency, an individual provider, or an AFH sponsor who performs these medically-oriented tasks.

Some facilities that hold contracts with the department also have private-pay beds. Some facilities are totally private and do not contract with the department. Clients not eligible for Medicaid or state payment for the cost of care in a department-contracted facility pay the private rate established by the facility. These clients may still be eligible for non-institutional medical assistance.

Assisted living facility (AL)

Most clients who live in a department-contracted AL are receiving COPES services. The department uses income and resource rules of the COPES program when determining their eligibility. There are also private facilities that are called “assisted living” facilities. The department determines eligibility for non-institutional medical assistance for a client who lives in one of these private facilities in the same way it does for a client who lives at home.

Domiciliary care in veterans homes

Residents of veterans homes who receive domiciliary care are not eligible for non-institutional medical assistance. The Department of Veterans Affairs is responsible for meeting the needs of such persons.

SSI-related program

Categorically needy (CN)

The income standard used to determine eligibility for non-institutional medical under the categorically needy (CN) program for a client who lives in an alternate living facility (ALF) is based on the department-contracted facility rate. The standard used is based on a thirty-one day month plus the PNA. If placement is made in an adult family home (AFH), an additional amount for "add-on hours" is added to the standard if such hours are authorized by the department-designated social worker (SW).

Rates vary for each facility and can be obtained from the division providing services in them or from facility staff.
Medically needy (MN)

The income standard used to determine eligibility for these benefits under the medically needy (MN) program is based on the private facility rate based on a thirty-one day month plus the PNA.

To be eligible for CN benefits, a client must have non-excluded income at or below both the CN standard and the SIL and resources at or below the resource standard. If the income exceeds the CN standard, the excess is used to determine the client's spenddown liability. Refer to **SPENDDOWN** for procedures to be followed.

Temporary assistance for needy families (TANF) or state family assistance (SFA) program

The department determines eligibility for non-institutional medical assistance in an ALF for a client related to medical eligibility by the TANF/SFA program according to the income and resource rules of those programs. Refer to WAC 388-454-0015 in **LIVING WITH A RELATIVE** for temporary absences from the home.

General Assistance GAU/X program

1. The income standard used to determine eligibility for benefits under this program is the department-contracted facility rate plus the PNA and any "add-on hours" authorized for a client living in an AFH. If contracted on a daily basis, multiply the daily amount by thirty-one.

2. The department authorizes a cash grant for the client whose non-excluded income is less than the payment standard described in WAC 388-478-0030. The amount authorized is the difference between the payment standard and the amount of non-excluded income. The cash grant standard for a client in an AFH is $339/mo. The client retains a PNA amount of $38.84/mo. and pays remaining income to the facility for the cost of board and room. The cash grant for a client in any other ALF is $38.84/mo.

3. If the client's non-excluded income is above the payment standard, but below the contracted rate, the department authorizes a suspended GA-U/GA-X grant. This allows the client not eligible for CN benefits to receive medical care services (MCS). ACES does not currently support this, and no workaround exists.

Chemical dependency/detoxification

The department provides payment to certain facilities for detoxification of acute conditions related to alcoholism or drug addiction. See **CHEMICAL DEPENDENCY** for eligibility requirements and authorization procedures.

Private boarding home, group or supportive living, tenant support, state operated living alternative (SOLA), continuing care retirement center (CCRC), and private AL facilities

The department determines eligibility for a client who lives in one of these community settings as it does for a client who lives at home. If the client's non-excluded income is at or below the categorically needy income level (CNIL), the client is eligible for CN benefits. Refer to WAC 388-478-0070. If non-excluded income is above the CNIL but below the medically needy income level (MNIL), the client is eligible for MN benefits with no spenddown. Refer to WAC 388-478-0080. Any income above the MNIL is the client's spenddown liability. **NOTE:** The CNIL and MNIL may be the same amount.

AGENCY RESPONSIBILITIES

Financial staff determine financial eligibility for financial and medical assistance programs. The division or agency responsible for placement and case management services determines the amount of participation the client must pay the facility and notifies the client.

WORKER RESPONSIBILITIES

1. See **CITIZENSHIP/ALIEN STATUS, RESIDENCY,** and **SSN** to determine whether a client meets the general eligibility requirements.

2. Determine the program to which the client can be related to medical eligibility. See **ADULT MEDICAL, FAMILY MEDICAL PROGRAMS**, and **INCAPACITY.**

3. See **INCOME** and **RESOURCES** to determine income and resource eligibility as follows:

   (a) When a client is placed in a facility on the COPES program, use the income and resource rules for COPES to determine eligibility.

   (b) When determining non-excluded income used to establish eligibility for the cost of care in the facility, use the CN income rules for an SSI-related client. Compare the result to the monthly income standard described in WAC 388-513-1305.

   (c) For the GA client, use the general assistance (GA) rules.

   (d) If the client's non-excluded income is above the SIL and/or the department-contracted rate plus the PNA, use the private facility rate plus the PNA.

(e) To determine the client's spenddown liability for non-institutional medical assistance under the MN program, use the client's non-excluded income in excess of the department-contracted rate plus the PNA to determine the client's spenddown liability. Do not use the cost of care to reduce the spenddown amount.

Refer also to WAC 388-506-0620 and **ADULT MEDICAL** for a client who is married.

4. Contact the facility for its PRIVATE rate. Contact the department-designated social worker (SW) for STATE-contracted daily rates.

5. Authorize cash assistance, if appropriate, as explained above under the GAU/GA-X programs. See **INCAPACITY**. Refer to the SW to request an exception to rule for participation to the facility when the spouse at home has income below the grant payment standard and does not qualify for assistance.

6. Certify CN or MN benefits according to procedures outlined in **CERTIFICATION PERIODS.**

7. When a client receiving these benefits transfers to another alternate living facility or goes home, redetermine eligibility and notify the SW. The SW determines any change in the participation amount and notifies the client and facility.

8. If a client dies, discontinue benefits effective the date of death and notify the SW. The SW determines any change in the participation amount and notifies the facility of any refund amount that is due.

9. Follow necessary supplemental accommodation (NSA) procedures described in chapter 388-200 WAC when appropriate.

ACES PROCEDURES

1. Refer to Chapter K 20.16.4 in the ACES User Manual. While following those procedures, the information below is important to remember.

2. For alternate care, G03 is the medical coverage group for CN benefits. G03 will trickle to G95 for MN without spenddown and G99 for MN with spenddown.

3. The key screens for eligibility calculations for a client in an ALF are DEM1, DEM2, and INST. DEM1 living arrangements must be Alternate Living (AF) or

the specific facility type. DEM2 must support ABD. Required information on the INST screen is Type, Entry Date, Level of Care and LTC rates for both Private and State. Enter only daily rates in these fields. Type is the specific code for the type of facility. Provider numbers are not required for this coverage group, and are not available using the F16-mmen function. Level of Care is Alternate Living Facility (L).

4. ACES will determine the correct medical coverage group and notify the client of approval for medical benefits or of approval for spenddown for medical benefits. ACES will not approve CN medical for a client with income above the SIL, regardless of the LTC rates.